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SOUTH CAROLINA Department OF Disabilities AND Special Needs

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TO: DSN Providers

FROM: Kathi K. Lacy, Ph.D.
Associate State Director for Policy

RE: Revised Directive 600-05-DD

DATE: April 16, 2010

The below-mentioned Internal Communication System (ICS) directive was recently revised. Please reference the table below for the number, name, and status of the directive.

Reference #	Directive Title	Status	Applicability
600-05-DD	Behavior Support, Psychotropic Medications, and Prohibited Practices	Revised	Intermediate Care Facilities for Persons with Mental Retardation, Community Day and Residential Programs and Non-Residential Programs

The following changes were made to the directive:

Changes in this directive were made to remove portions that were standards rather than policy and move them into a separate document.

Attached are the Directive and the Behavior Support Standards.

Please send any comments to Anne Mclean (amclean@ddsn.sc.gov) by May 14, 2010. You may comment on either document or both. Thank you.

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Reference Number:	600-05-DD
Title of Document:	Behavior Support, Psychotropic Medications, and Prohibited Practices
Date of Issue:	June 1, 1987
Effective Date:	June 1, 1987
Last Review Date:	July 1, 2007
Date of Last Revision:	April 12, 2010
Applicability for Persons Receiving Services in:	Intermediate Care Facilities for Persons with Mental Retardation, Community Day and Residential Programs and Non-Residential Programs

PURPOSE

To establish the expectations of the Department of Disabilities and Special Needs (DDSN) regarding behavior support, the use of psychotropic medications, approvals needed for use of behavior support interventions, and identification of prohibited procedures.

I. PHILOSOPHY

POSITIVE BEHAVIOR SUPPORT

Positive behavior support recognizes that people exhibit problem behavior because it serves a useful purpose for them in their current situation. The focus of positive behavior supports begins with understanding the function of the problem behavior. Once it is known why the problem occurs for an individual, procedures can be developed to teach and promote alternatives that can

replace the problem behavior. The goal is not just to eliminate the undesirable behavior. The focus should be to create environments and patterns of support for the person that makes the problem behavior irrelevant ineffective, or inefficient. The key outcome of positive behavior supports should be an improvement in quality of life for the person that includes the replacement of problem behavior(s) with appropriate alternatives that serve the same purpose. It is the philosophy of DDSN that people will be free from any serious risk to physical and psychological health and safety at all times, including during the development of a Behavior Support Plan (BSP). Procedures used to insure safety should not be misunderstood to substitute for procedures to provide positive behavioral supports.

DDSN believes that those who develop BSPs must be knowledgeable in the values, theory, and practices of positive behavioral support as provided in the "Functional Assessment and Program Development for Problem Behavior: A Practical Handbook" by O'Neill, Horner et. Al. (Brookes/Cole Publishing Company, 1997) or other similar guides to effective, evidence-based practices in positive behavioral support.

Positive approaches to behavior support should be included for all new direct support and supervisory employees as part of their pre-service orientation program (but use of the Carolina Curriculum on Positive Behavior Support/AAIDD Positive Behavior Support Training Curriculum should be only for staff who have at least 30-60 days on the job). Positive approaches to behavior support should be reviewed periodically with employees who have direct contact with persons served by DDSN.

BSPs must be developed in accordance with DDSN Standards for Behavior Support Services. They also need to comply with DDSN standards for Residential Habilitation, and/or Day Services as applicable.

Each DSN contracted provider must adopt and implement written policies and procedures governing the assessment, prevention, and management of inappropriate behavior. These policies and procedures must specify all facility or program-approved procedures use for inappropriate behavior. A primary focus is to be on the prevention of problem behavior by using functional assessment data to identify appropriate alternative behaviors to teach and/or reinforce. When consequence-based procedures are to be used, each DSN contracted provider must designate these procedures on a hierarchy, ranging from most positive or least intrusive, to least positive or most intrusive. These procedures must address the following: the use of restraints; the use of medications to manage inappropriate behavior; and the use of aversive consequences.

II. USE OF PSYCHOTROPIC MEDICATIONS

Psychotropic medications are defined as any medication used for the primary purpose of affecting overt maladaptive behavior, mood, thought process, or alleviating symptoms related to a specific diagnosed psychiatric condition.

PRN orders for psychotropic medications are specifically prohibited.

Psychotropic medications will be accompanied by a BSP if the person's problem behavior poses a significant risk to him/herself, others, or the environment (i.e., self-injury, physical aggression or property destruction).

For people residing in an ICF/MR, a BSP is always required if they are receiving psychotropic medication. The overall effort that includes the BSP should lead to a less restrictive way of managing and, if possible, eliminating the behaviors and/or psychiatric symptoms for which the medications are employed.

A person and/or their family cannot elect not to have a BSP when a person is prescribed psychotropic medications for problem behavior(s) and/or psychiatric symptoms that pose a risk to the person, peers, or the environment and interfere with the person's daily functioning.

Medication may not be used for disciplinary purposes, for the convenience of staff, as a substitute for a habilitative training program, or in quantities that interfere with a person's quality of life. Each plan should document the fact that any potential risks of the medications employed have been carefully weighed against the risks of the behavior for which the medications are given.

Psychotropic medications should be used only with appropriate consent pursuant to DDSN Directive 535-07-DD: Obtaining Consent. When psychotropic medications are given, the person must be monitored for Tardive Dyskenesia (TD) in accordance with DDSN Directive 603-01-DD.

Psychotropic medications should be reviewed based on the person's needs as determined by the psychiatrist or physician and at least quarterly in a psychotropic drug review (PDR) process. Persons involved in this process should include, but are not limited to, the physician, person receiving supports and, if the person is not their own legal guardian, the legal guardian, an approved provider of behavioral supports (or psychologist in ICFs/MR), program supervisor, caregiver who knows the person well, nurse (for people in ICF/MRs), and psychiatrist, if applicable. These people comprise the PDR team. The PDR process should provide for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence justifies that the medication is helping the individual.

When psychotropic medication is used, the team will specify which behaviors/psychiatric symptoms are target for change and should, therefore, be monitored both for desired effects and adverse consequences/reactions.

Approval: The PDR Team, Human Rights Committee (HRC), physician, Facility Administrator (FA) or Executive Director (ED), and the individual or if the person is not their own legal guardian, the legal guardian.

Monitoring: The program director or program supervisor; PDR Team psychiatrist, or attending physician.

Monitoring in Day Programs: In a day program, the directors (as a member of the team) with the approved provider of behavioral supports (or psychologist if the person is served in an ICF/MR) have responsibility, and in other community residential programs (i.e. CTH and SLP) the responsibility will be that of the program supervisor and approved provider of behavioral supports.

For persons residing in ICF/MRs, a BSP must be in place when psychotropic medications are prescribed for any challenging behavior(s). This is consistent with the S.C. Code Ann. §44-26-10 and Federal Regulations W-311 and W-312 which include that "drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards reduction of and eventual elimination of the behaviors for which the drug is employed," and "the interdisciplinary team involvement in this decision-making process is inextricably linked to an obligation to develop and implement effective non-drug interventions that address the targeted behavior."

A BSP is not required for those receiving Residential Habilitation, or a DDSN-funded day service and psychotropic medication when the person's record documents that:

- The person does not exhibit physical aggression, self-injury, or property destruction or other behaviors that pose a significant risk of harm to themselves, others or the environment. This must be documented by data collected by direct support staff and summarized by the local agency personnel or consultants.
- The person has reached the lowest effective dosage of the medication based on data collected on symptoms/problem behavior of the person and determined in the PDR process.

This documentation must be in the person's record and reviewed/updated annually for as long as the person receives the medication.

When people who reside at home with family and are prescribed psychotropic medications by a private physician (at the referral and request of the family/guardian) the service coordinator should attempt to obtain information/documentation about the prescribed medications and reason for their use.

When medications are prescribed for a consumer living at home with family to alleviate psychiatric symptoms and/or behavior problems the person should be offered behavior support services. If a BSP is developed, the author of the BSP is responsible for monitoring the program and training the caregivers to record data and implement the plan. If the individual or the family will not provide information about psychotropic medications prescribed, decline offered behavioral supports, and/or report no behavior problems which interfere with activities of daily functioning and community living, then this information must be documented in the person's plan and/or file. Such documentation must always be available in the individual's record and documentation reviewed/updated annually as long as the medication is prescribed.

III. BEHAVIOR SUPPORT PLAN REVIEW AND APPROVAL

In accordance with DDSN Directive 535-02 DD: Human Rights Committee, each provider must designate and use a HRC to review, approve, and monitor individual plans designed to manage inappropriate behavior and other plans that, in the opinion of the committee, involve risks to individual protection and rights. Individual plans that involve risk, including but not limited to those procedures designated by the provider's policies and procedures as being restrictive, require consent pursuant to DDSN Directive 535-07-DD: Obtaining Consent.

Nonrestrictive Procedures

When BSPs contain only procedures defined as nonrestrictive by DSN provider policy because the procedures do not limit freedom or cause loss of personal property or rights they are considered nonrestrictive.

Examples of non-restrictive procedures include but are not limited to, teaching appropriate (and functionally related) replacement behavior, differential reinforcement, social disapproval, ignoring, simple correction, re-direction, and interrupting behavior with educative prompts.

Approval must be obtained from the person or the legal guardian if the person is not their own legal guardian. For people served in an ICF/MR the BSP must be approved by the Interdisciplinary Team. For all others, the BSP must be approved by the service coordinator, the residential coordinator (if appropriate) and the day services director (if appropriate).

Monitoring: Program director or program supervisor, day program director (if individual is in a day program) and an approved provider of behavioral supports.

Note: Procedures listed in the examples above are often used in everyday generic training by staff and would not require specific team approval unless made part of a BSP.

Restrictive Procedures:

When BSPs contain procedures that limit freedom or cause loss of personal property or rights they are considered restrictive.

Examples (not all inclusive): Residence restriction, 1:1 staffing or increased level of supervision/accountability, response cost, overcorrection, extinction where there is a risk of harm to self or others, and separation procedures lasting more than 5 minutes (excluding the use of timeout rooms).

Approval must be obtained from the person and if the person is not their own legal guardian the legal guardian, and the HRC. If the person resides in an ICF/MR, the Interdisciplinary Team must approve the BSP. For all others, the BSP must be approved by the service coordinator, the residential coordinator (if appropriate) and the day service director (if appropriate).

Monitoring: Program director or program supervisor, day program director if in a day program, and approved provider of behavioral supports, and the HRC.

Restraint Procedures

Restraint procedures may only be included in a BSP when necessary to protect an individual or others from harm and when the procedures are the least restrictive alternatives possible to meet the needs of the person.

Restraint is defined as ***a procedure that involves holding an individual (i.e., manual restraint) or applying a device (i.e., mechanical restraint) that restricts the free movement of or normal access to a portion or portions of an individual's body.***

Note: The use of mechanical devices, such as splints or braces, bed rails to prevent injury, wheelchair harness and lap belts to support a person's proper body positioning are not considered restraint even though they may restrict movement. Such medical necessity for these devices must be documented in the person's record.

Use of restraint is limited to a **maximum** of one (1) continuous hour. Release from restraint must occur when the person is calm and is **no longer** a danger to self or others. It should be quite rare for the maximum restraint duration to be used. Plans that include restraint must also include strategies directed toward reducing dependency on its use. A physician's order for restraint is needed but is not required at the time of each use. The order may be included in the routine medical orders which are renewed per state licensure requirements.

Mechanical restraint procedures should be designed and used in a manner that causes no injury and a minimum of discomfort. While in mechanical restraint, the individual will be under continuous observation with documentation of their response to the restraint every ten (10) minutes with a maximum duration not to exceed one (1) continuous hour. This documentation should include the physical condition of the individual (i.e., breathing, circulation).

Approval: When restraint procedures are included in a BSP, approval must be obtained from the person and if the person is not their own legal guardian the legal guardian, the Interdisciplinary Team (if served in an ICR/MR), the FA/ED, and the HRC.

Monitoring: Program Director or program supervisor, team, a professional that meets DDSN MR/RD Waiver qualification for behavior support, day program director if in a day program, and the HRC.

Mechanical restraint used for behaviors that do not produce immediate harm but through their chronic/long term nature may result in infrequent harm (e.g., hand mouthing which produces skin breakdown) may be used to allow for healing of injury produced by the inappropriate behavior. If a behavior causes an injury requiring the temporary use of restrain to allow healing,

the Team must meet and address the behavior that produced the injury. If the Team develops a BSP to incorporate the restraints, it must include:

a. A schedule for use which specifies checks of the individual's condition every 30 minutes or more frequently depending on the type of device and well-being of the person. The schedule will provide for release ten (10) minutes at least every hour for motion, exercise, liquids, and bathroom use.
b. A plan for supervision while out of restraint and a plan for teaching appropriate replacement behavior must be included.
c. Procedures to insure that restraint is not automatically reapplied after release unless the problem behavior reoccurs or a medical condition exists.
d. Provisions for application of less intrusive methods prior to application of restraints when the problem behavior is occurring.

Approval: When restraint procedures are included in a BSP, approval must be obtained from the person and if the person is not their own legal guardian the legal guardian, the Interdisciplinary Team (if served in an ICF/MR), the FA/ED, and the HRC.

Monitoring: Program Director or program supervisor, day program director if the individual is in a day program, an approved provider of behavioral supports, and the HRC.

Note: See also S.C. Code Ann. §44-26-160: Mechanical, Physical, or Chemical Restraint of Clients; and S.C. Code Ann. §44-26-170: Use of Certain Types of Behavior Modification.

IV. PROHIBITIONS

The following are prohibited:

1. Procedures, devices, or medication used for disciplinary purposes, for the convenience of the staff or as a substitute for necessary supports for the person.
2. Seclusion (defined as the placement of an individual alone in a locked room).
3. Enclosed cribs.
4. Programs that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal.
5. Having a DDSN consumer discipline peers.
6. Prone (i.e., face down on the floor with arms folder under the chest) basket-hold restraint.
7. Timeout rooms
8. Aversive consequences (defined as the application of startling, unpleasant, or painful consequences) unless specifically approved by the State Director or her designee.

V. USE OF RESTRAINT AS A HEALTH RELATED PROTECTION

Definition: Restraint (chemical, physical, or mechanical) used during the conduct of a specific medical/dental or surgical procedure, or only if absolutely necessary for a person's protection during the time that a medical condition exists.

The physician/dentist must specify the scheduled use of restraint and its monitoring. If a restraint is applied to prevent a person from removing post-operative sutures, documentation/release requirements would apply since the primary purpose is to manage behavior.
Note: The use of restraint as a health-related protection does not require the development of a BSP.

Note: ICF/MRs should see also DDSN Directive 603-03-DD: Managing Maladaptive Behavior during Dental Procedures.

VI. EMERGENCY PROCEDURES

Definition: Procedures used to provide protection from harm in situations where the person is endangering him/herself or others with severely aggressive or destructive behavior. These behaviors could not reasonable have been anticipated in the current setting and there is no approved behavioral, medical or psychiatric program in effect that provides adequate protection from harm.

Authorized emergency procedures are those defined in DDSN Directive 567-02-DD: Preventing and Responding to Aggression, and procedures outlined in the MANDT, Crisis Prevention (CPI), or Professional Crisis Management (PCM) curriculum. Emergency situations involving the use of psychotropic medication or mechanical restraint shall be authorized in writing by the FA/ED or their designee (or approved by the physician if involving transport to the emergency room) and a report of that emergency provided to the physician or psychiatrist, FA/ED or their designee and an approved provider of behavioral supports within 24 hours.

The FA/ED must be notified whenever a designee authorizes emergency restraint. Orders for emergency restraint must not exceed 12 hours during which the person's condition must be documented at least every ten (10) minutes. This 12-hour period is the timeframe in which emergency restraints are authorized, not the duration of the restraint. Each use of emergency restraint and justification for its use, including less restrictive methods that have failed, must be noted in the person's record. Emergency mechanical restraints require opportunities for exercise at least ten (10) minutes every hour. This means that the maximum duration of such restraint is 50 consecutive minutes.

The person's legal guardian must be notified immediately of the use of emergency restraint, unless the Team, in conjunction with the legal guardian, has documented other agreed upon timelines for notification or if the person is their own legal guardian and does not want their family notified.

The HRC must be notified of the use of emergency restraint according to a scheduled established by the facility or program. PRN orders for mechanical restraint or psychotropic medication are not permitted (unless prescribed by the Emergency Room Physician). Once a "pattern" of use emerges (i.e., three (3) restraints within a 90-day period of time), the Team must meet and

develop a plan/strategy for how to prevent escalation or how the Team will respond when behavior does escalate, other than emergency restraint.

Kathi K. Lacy, Ph.D.
Associate State Director–Policy
(Originator)

Beverly A.H. Buscemi, Ph.D.
State Director
(Approved)

To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number.

Attachments:

A. Components of Meaningful Environments & Specialized Services
B. Examples of Informal Behavioral Guidelines and Interventions (2)

South Carolina Department of Disabilities
And
Special Needs

Behavior Support Services Standards

Effective December 1, 2009

MISSION

The mission of the South Carolina Department of Disabilities and Special Needs (DDSN) is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals and minimize the occurrence and reduce the severity of disabilities through prevention. Consistent with the Agency's mission, the intent of DDSN Behavior Support Services is to provide people with Mental Retardation/Related Disabilities (MR/RD), Autism, and Head and Spinal Cord Injury (HASCI), and similar disabilities the supports needed in order for them to meet their needs, pursue possibilities, and achieve their life goals.

DEFINITION

Behavior support services are those services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key persons, collection of objective data, analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.

Behavioral intervention in the form of a Behavior Support Plan (BSP) are required to address destructive behaviors (i.e., physical aggression, self-injury, and property destruction). They may also be used to address other problem behavior that has a negative impact on the quality of life for a person served by DDSN.

One (1) unit of behavior support services equals 30 minutes of service provision. Partial units may be billed; however, rounding up is not allowed.

Behavior support must not be provided in a group setting or to multiple recipients at once.

PHILOSOPHY

Positive behavior support recognizes that people exhibit problem behavior because it serves a useful purpose for them in their current situation. The focus of positive behavior supports begins with understanding the function of the problem behavior. Once it is known why the problem occurs for an individual, procedures can be developed to teach and promote alternatives that can replace the problem behavior. The goal is not just to eliminate the undesirable behavior. The focus should be to create environments and patterns of support for the person that makes the problem behavior irrelevant, ineffective, or inefficient. The key outcome of positive behavior supports should be an improvement in quality of life for the person that includes the replacement of problem behavior(s) with appropriate alternatives that serve the same purpose. It is the philosophy of DDSN that people will be free from any serious risk to physical and psychological health and safety at all times, including during the development of a BSP. Procedures used to

insure safety should not be misunderstood to substitute for procedures to provide positive behavior supports.

Those who develop BSPs must know the values, theory, and practices of positive behavior support as provided in the "Functional Assessment and Program Development for Problem Behavior: A Practical Handbook" by O'Neill, Horner et. Al. (Brookes/Cole Publishing Company, 1997) or other similarly recognized guides to effective, evidence-based practices in positive behavior support.

STANDARDS

1. Behavior support services may only be provided by those who have met and continue to meet specified criteria as indicated by approval as a provider of behavior support services under the Medicaid waiver.

2. Providers of behavior support services must satisfy specified continuing education requirements.

3. When psychotropic medication is used to address problem behavior that poses a significant risk to the person receiving the service, others, or the environment (e.g., self-injury, physical aggression, property destruction) the Behavior Support Plan (BSP) must address the specific behavior (or psychiatric symptoms) for which the medication is given.

   A BSP is not required for consumers receiving psychotropic medication to treat a psychiatric disorder when the record documents that:

   - The person does not exhibit behaviors that pose a significant risk of harm to themselves, others or the environment.

   GUIDANCE: This would be documented by data collected by direct support staff and summarized by the local agency personnel or behavior support services provider.

   - The Psychotropic Drug Review team, including the psychiatrist or physician with expertise in developmental disabilities has determined that the person has reached the lowest effective dosage of the medication based on data collected on symptoms/problem behavior.

   GUIDANCE: This written documentation needs to be in the persons' record and reviewed/updated annually for as long as the person receives the medication.

4. An initial assessment to determine the need for and appropriateness of behavior support services must include the components of a functional assessment.

   GUIDANCE: The components include staff interviews, reviewing and/or creating operational definitions of behavior and initial observation of the person (with A-B-C data collection).

- Initial assessment should begin as soon as possible following acceptance of a referral.

5. Prior to implementation of a BSP, a functional assessment must be completed.

GUIDANCE: Functional assessment results must be specific to each target behavior. As O'Neill et al. pointed out (see page 2 of these standards), key outcomes of a functional assessment include:

a. A clear description of the problem behavior including the classes or sequences of behavior that frequently occur together.
b. The events, times, and situations that predict when the problem behaviors will and will not occur across the full range of typical.
c. The consequences that maintain the problem behaviors (that is what function(s) the behaviors appear to serve for the person) are identified.
d. One or more summary statements or hypotheses that describe specific behaviors, a specific type of situation in which they occur, and the outcomes or reinforces maintaining them in that situation are developed.
e. Direct observation data that support the summary statements that have been developed are collected.

To appropriately address the intended outcomes of a functional assessment (above) the functional assessment must include:

a. Conducting staff and/or caregiver interviews for preliminary information.
b. Defining behavior in objective and measurable terms (behaviors to increase and decrease).
c. Use (possibly to include design) of appropriate data collection systems.
d. Application of data collection to determine where, when, and why problems occur.
e. Training staff and/or caregivers to collect behavioral data.
f. Direct observation of behavior that includes data using objectively defined terms on more than one occasion and in the settings in which the problems occur.
g. Data analysis to determine function of behavior (including A-B-C) analysis.
h. Assessment of the consumer's preferences, reinforcers, and potential reinforcers.
i. Identification of replacement behavior that serves the same function as the problem behavior (for each problem behavior or class of problem behaviors).
j. The use of graphs that provide for demonstration of intervention effect.

The following are important issues for consideration and/or implementation in developing behavior support services:

a. Behavior rating scales/checklists.
b. Consideration of:
    1. Risks of the problem behavior(s) to the person, others, and the environment.

2. The therapeutic quality of the person's environment including: training opportunities, social interactions, functional activities, environmental accommodations, community inclusion and training, and monitoring of those implementing plan.
3. Relevant sensory strengths and deficits.
4. The person's functional communication skills.
5. The person's sleep and eating patterns.
6. The person's physical/medical condition, including medical syndromes that may have an impact on problem behaviors.
7. The person's psychiatric condition, if possible.
8. Medication effects and side effects.
9. Historical information from family, previous staff, and relevant others.

Unless exceptional circumstances exist, functional assessments should be completed with 30–45 days of initiation.

6. Precautionary measures to protect the person and others from harm shall always be taken during the course of functional assessment of problem behavior.

GUIDANCE: In an "emergency" or urgent situation, safety must be assured and it would be inappropriate to delay intervention for the weeks that a typically functional assessment may take to complete. In such (hopefully rare) situations, interim written interventions may be appropriate. These interventions would have the primary intent of insuring safety and providing potential reinforcement for appropriate behaviors. At the same time, the functional assessment should be implemented so that once completed, it will provide key information on the motivation for the problem behavior that would be included in the development of the actual BSP.

7. All documents (i.e., data analysis, summary, and report) that comprise the functional assessment must be readily available for review as long as the BSP is implemented.

8. BSPs must contain the following elements:

a. Identifying individual information, such as name, age, skills, interests, level of functioning, home address, date of BSP, and signature of the professional who was lead author of the BSP.
b. An operational definition of each problem behavior to be decreased.
c. An operational definition of each replacement behavior to be increased.
d. A measurable objective for each problem behavior and replacement behavior.
e. Procedures for teaching and/or reinforcement of replacement behavior as an alternative for achieving the function of the problem behavior(s).
f. Procedures specific to each problem behavior that specifically addresses prevention, replacement, and management of each problem behavior.
g. The type of data to be collected to assess progress toward the objectives(s) for behaviors to be increased and decreased.

9. Prior to implementation, those expected to implement the BSP must be trained. Documentation must be available to support that training was provided.

GUIDANCE: Training responsibility rests with the BSP author. However, approved providers of behavior supports can train a trainer for a specific plan (e.g., the BSP author may train a designated staff person to teach others about a person's BSP). Approval for a local staff member to train others on a specific BSP must be documented. Approval may only be given for the person's current plan. It is expected that anyone providing training on a BSP will be able to provide practical information, answer questions, and skillfully demonstrate any procedures in the plan. Training must include information on how to collect behavioral data.

10. Plans that involve risks to individual protection and rights including those designated by the provider as being restrictive must be reviewed and approved by the Agency's Human Rights Committee prior to implementation and annually thereafter.

GUIDANCE: See SCDDSN Policy 535-07-DD: Obtaining Consent for Minors and Adults.

11. Consent pursuant to SCDDSN Policy 535-07-DD: Obtaining Consent for Minors and Adults, must be obtained.

12. Once a BSP has been implemented, data must be collected.

GUIDANCE: Unless exceptional circumstances exist, the BSP should be implemented with two (2) weeks of the completion of the functional assessment.

13. Data collected must be reviewed at least monthly by a designated staff member and an approved provider of behavior support services.

14. Data must include a graph on which data is graphed in a manner which notes changes in BSP procedure, psychotropic medications, and significant environmental variables and over sufficient duration to facilitate detection of trends and patterns.

15. The BSP is not considered to be current and therefore must be amended when:

- No progress is being made;
- A new intervention, strategy or support is warranted.

GUIDANCE: BSPs do not have to be updated annually or have an annual statement of need. However, BSPs should be revised as needed and must always be current.